AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: ____ Date of Birth: _____________
Last First Middle

Patient's Address: __________________________ City _____________State _____ Zip _______

Home/Business Phone _______________ Cell Phone: _____________ E-Mail: ________________

PERSON OR ENTITY TO RELEASE INFORMATION

☐ Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

PERSON OR ENTITY TO RECEIVE INFORMATION

☐ **The Pain Management Center**

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed)

____ Complete Medical Record ___Office Notes ___ Lab Reports

____ Procedure Reports ___ Surgery Records ___ Billing Records

______________________________ Other (Specify)

DATES OF SERVICE: ____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance.
___ Workman's Compensation, ___ Other ____

This authorization will expire on ____________________. (If no date specified, this authorization shall expire 1 year after date signed.)

CHECK AND INITIAL BELOW:

___ I DO, ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS related conditions**, and all medical records and clinical information relating thereto. *(Initials of individual giving authorization*) _________.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**. (*Initials of individual giving authorization)* _________.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment. *(Initials of individual giving authorization*) _________.

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and/or information.

______________________________ ______________________________
Signature of Patient or Patient's Representative Witness

______________________________ ______________________________
Relationship to Patient Date
(if applicable, attach document of guardianship or Power of Attorney)